HOME AND COMMUNITY-BASED SERVICES

WYOMING MEDICAID
DIVISION OF HEALTHCARE FINANCING

Community Choices Waiver Provider Manual

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Please note that, for the purposes of this manual, "provider" includes provider staff and case managers, unless there is a specific need to make a distinction.

Section 1. Community Choices Waiver Overview

The Community Choices Waiver is a Medicaid home and community-based services (HCBS) waiver program. Medicaid HCBS waivers provide services to participants in their community as an alternative to institutional care. The Wyoming Department of Health, Division of Healthcare Financing (Division) includes the Home and Community-Based Services Section, which administers the Community Choices Waiver (CCW). This manual relates specifically to provider requirements and regulations for CCW providers. There is a supplemental Case Management Manual containing additional guidance for case manager daily practices.

Home and Community-Based Services Background

The CCW program provides community-based alternatives to nursing facility care for older adults and adults with a disability, as determined using the Social Security Administration (SSA) determination criteria. The goal of the CCW program is to support participants in achieving independence, maintaining health and safety, and fully participating in community living. This goal is accomplished through access to community-based services. In order to achieve this goal, the CCW program provides reimbursement to qualified providers who deliver these services.

CCW services are authorized pursuant to the Wyoming Medical Assistance and Services Act [W.S. §42-4-103(a)(xvii)] and §1915(c) of the Social Security Act [42 U.S.C §1396n]. The Division's application for the CCW program has been approved by the US Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). The approved application, commonly known as the "CCW Agreement", can be found at the following link, under the *Current Waivers* tab:

https://health.wyo.gov/healthcarefin/hcbs/hcbs-public-notices/.

The CCW Agreement establishes the requirements that the State of Wyoming has agreed to meet, and is a primary source of requirements for providers, case managers, participants, and Division personnel. In addition to the requirements established in the CCW Agreement, there are a number of federal regulations that govern all HCBS programs. Wyoming Medicaid Rules and subregulatory guidance developed by the Division is also available to support providers in serving participants of the CCW program.

This manual serves as one resource in navigating the various requirements of CCW providers. It is not intended to replace the regulatory documents or technical assistance. Providers are responsible for being knowledgeable about CCW program requirements, and are encouraged to review the HCBS Section website for up-to-date information and guidance.

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CCW Program Philosophies

Person-Centered Planning

All HCBS programs are based on the tenet of person-centered services, so the participant's needs, desires, and choices must always be elicited and respected. In the CCW program, the participant takes an active role in planning for their services. The case manager develops the participant's service plan using a person-centered planning process, during which the individual identifies their interests, needs, and goals that are ultimately incorporated into the service plan. Services identified in the plan must be provided in the most integrated setting appropriate for the individual's needs. Person-centered planning and settings for services will be discussed later in this manual.

Participant Choice

A foundational CCW program philosophy is that people have the freedom to make choices that impact their lives. Whether the choices are related to big decisions such as who provides their services, where they live, or what they want for their future, or small decisions such as with whom they spend time, what and when they eat, and how they spend their day, having choice is paramount to human dignity. Facilitating individual choice is a crucial part of being a CCW provider, and will be discussed further in this manual.

One of the foundational choices that a participant has is the right to choose the services they receive and the providers that deliver these services. This right is protected by federal and state rules and regulations. Each participant chooses their providers from all qualified providers, and may change their choice at any time. Case managers are responsible for coordinating and supporting participant choice. A searchable list of qualified providers is available on the HCBS Section website at https://health.wyo.gov/healthcarefin/hcbs/.

The provider is responsible for ensuring that services are in alignment with these programmatic philosophies, and that the focus is on the needs, wishes, and goals of the participants.

CCW Program Objectives

In order to support program goals, the CCW program has developed program objectives to guide the administration of the CCW program and ensure that the participant's experience is the primary focus for Division personnel, participants, providers, case managers, and family members. These program objectives are outlined in Table 1.

Table 1
CCW Program Objectives and Descriptions

Objective	Description
Individual authority over services & supports	Ensure participants have the opportunity and authority to exert control over their services, supports, and other life circumstances to the greatest extent possible.

Person-centered service planning & service delivery	Acknowledge, promote, respect, and support participant strengths, goals, preferences, needs, and desires through a person-centered service planning process and person-centered service delivery.
Community relationships	Support and encourage participants to be active members of their communities. Recognize that the nature and quality of community relationships are central to participant health and wellness.
Health & safety	Effectively manage risk and balance the participant's ability to achieve independence and maintain health and safety.
Service array	Offer services that complement or supplement the services that are available through the Wyoming Medicaid State Plan and other federal, state, and local public programs, as well as the support that families and communities provide to participants.
Responsible use of public dollars	Demonstrate sound stewardship of limited public resources.

CCW Program Administration

The CCW is administered by the Division. The Home and Community-Based Services (HCBS) Section manages and monitors the operations of the CCW. The HCBS Section is comprised five Units that support the CCW program: Benefits and Eligibility, Operations, Policy and Communications, Provider Support, and Quality Improvement. Providers of CCW services will work closely with the Benefits and Eligibility and Provider Support Units.

Benefits and Eligibility Unit

The Benefits and Eligibility Unit works with case managers and participants of the CCW. Each county in the state has an assigned Benefits and Eligibility Specialist (BES). These assignments are available on the Contacts and Important Links page of the HCBS Section website (https://health.wyo.gov/healthcarefin/hcbs/). The role of the BES is to support case managers in developing and maintaining service plans, assist and process eligibility, and provide ongoing case manager education and guidance.

Provider Support Unit

The Provider Support Unit works with providers to establish and renew certification, investigate incidents and complaints, and guide providers in maintaining compliance with the regulatory processes of the CCW. The Provider Support Unit is divided into the Certification and Credentialing team and the Incident Management team. The Certification and Credentialing team is available by contacting wdh-hcbs-credentialinga@wyo.gov. Each county in Wyoming has

an assigned Incident Management Specialist (IMS). These assignments are available on the Contacts and Important Links page of the HCBS Section website.

HCBS Section Website

Throughout this manual you will find links and references to the HCBS Section website. Searchable provider lists, current waiver documents and rules, required forms, manuals, fee schedules, the CCW Service Index, links to various systems, and important contact Information is available on the website. Providers are encouraged to bookmark the website and refer to it often, The website is located at https://health.wyo.gov/healthcarefin/hcbs/.

Participant Rights and Responsibilities

Participant Rights

An important and essential element of the CCW program is supporting and promoting participant rights. Human rights are inherent to all human beings, regardless of race, sex, gender identity, sexual orientation, nationality, ethnicity, language, religion, disability, or any other status. Human rights include the right to life and liberty, freedom from slavery and torture, freedom of opinion and expression, the right to work and education, and many more. Everyone is entitled to these rights, without discrimination. Each participant receiving services has the same legal rights and responsibilities guaranteed to all other U.S. citizens under the United States and Wyoming constitutions, and federal and state laws.

In addition to basic human rights, participants of the CCW program have specific rights established in federal law and in the CCW Agreement. These rights shall not be denied or limited, except to address a health or safety need. While some participant rights can be restricted in limited situations and will be discussed later within this manual, there are some rights that a provider cannot restrict under any circumstances during the course of providing CCW services. These rights include:

- Dignity;
- Respect;
- Freedom from abuse and neglect; and
- Freedom from seclusion.

Treating participants with dignity and respect is critical to providing CCW services. This means that the provider:

- Honors the participant's preferences, interests, and goals;
- Facilitates opportunities for participants to make their own choices;
- Encourages participants to express their wishes, desires, and needs; and
- Designs services to meet the participant's individual needs.

Case managers are responsible for ensuring that participants are informed of their rights and responsibilities, providing participants the support needed to exercise them, and documenting that participants have been provided this information. Case managers must explain these rights to participants in such a manner as to ensure they understand them. Participant rights and responsibilities are included in the Participant Handbook and on the participant's copy of the service plan. Case managers must review each right and responsibility with the participant, and answer any questions that may arise as part of the service planning process, on at least an annual basis.

Participant Responsibilities

Participants receiving CCW services have responsibilities as well. These responsibilities include:

- Actively participating in the person-centered planning process.
- Providing information necessary for service planning and delivery.
- Attending and participating in meetings, and engaging in evaluation activities.
- Being familiar with service definitions outlined in the CCW Service Index, including the service scope and limitations. Providers have agreed to follow the service plan and provide services in compliance with the CCW Service Index definitions. Participants are not entitled to services outside of the scope of the CCW Service Index and service plan.
- Discussing needs that are outside the scope of the service with their case manager.
- Engaging in services and providing notice if they are unavailable or unwilling to participate in services.
- Participating in monthly visits with case managers, and identifying any service delivery issues or needs that arise.

HIPAA and Privacy

All providers are expected to abide by federal regulation, which includes the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Pub. L. No. 104-191. This law is more commonly known as HIPAA. It is the responsibility of each provider to comply with HIPAA and protect the health information of each participant. Additionally, all participants have a right to privacy, which includes their health information and any other details that may make them personally identifiable. CCW providers are required to have HIPAA-complaint policies and procedures in place, and behave in a way that protects each participant's personal information and ensures their privacy while providing services.

Refusal of Services

Home and community-based waiver services are voluntary. Participants have the right to refuse these services, even for an hour or a day. As an example, a participant can choose to stay home rather than attending day time services. While participants have the right to refuse services, it is still important for the provider to encourage participation. A participant choosing to stay home and just relax for a day is understandable; however, unless there is a health related concern, a participant's consistent refusal of services may indicate that the services the participant is receiving are not meeting their needs. Providers should talk to the participant and work to understand why the participant is not engaged in their services. If necessary, the

provider should request a team meeting so the team can work with the participant to identify what isn't working, and get input as to what needs to change so the participant is ready and willing to participate. In the event that a participant refuses services, the provider cannot charge the participant a monetary fee or impose any sort of disciplinary action.

Home and Community-Based Setting Requirements

In 2014, CMS published changes to the federal regulations which govern the administration of all Medicaid HCBS programs, including the CCW. These rule changes were designed to enhance the quality of Medicaid HCBS and provide additional protections to participants in several different areas.

These federal regulations, commonly referred to as the Final Settings Rule, are geared towards supporting participants to live as full and active members of their communities. In order to accomplish this goal, services must not have the effect of isolating or segregating participants from their community. Services must encourage and support participants in accessing their communities. More detail regarding settings requirements can be found in Section 5 of this manual.

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Section 2. CCW Services and Provider Qualifications

The CCW program funds an array of services designed to support participants in being active members of their communities. The services that are available to participants are outlined in the Community Choices Waiver Service Index (Service Index).

Service Delivery Options

Participant's of the CCW program must be offered choice in how their services are delivered. A participant may choose for services to be delivered through a traditional agency-based model, through a participant-directed model, or through a combination of the two models. Details about these service delivery options are outlined below.

Agency-Based Services Option

When the participant chooses the agency-based service option, the participant selects a qualified provider agency, and that agency delivers waiver services through its own employees and business model. The participant does not have the authority to hire caregivers, set wages, or direct business operations. The agency is responsible for delivering services for participants in accordance with the service plan and state and federal rules and regulations.

Participant-Directed Services Option

The participant-directed service delivery option is available only for Personal Support Services. When the participant selects this option, they exercise decision making authority and accept the responsibility for taking the direct role in managing the service. Case managers must inform participants of the participant direction opportunities available under the CCW program, and ensure that participants who express an interest in participant direction are informed of the potential benefits, liabilities, risks, and responsibilities associated with this service delivery option. Participants who are unable to, or uncomfortable with, directing their own services may also choose to designate another individual to act as the employer of record and manage the participant directed activities and responsibilities on their behalf. More information on the participant-directed service delivery option can be found on the CCW Participant Services and Eligibility page of the HCBS Section website.

Service Limits

Services Provided by Relatives and Legally Responsible Individuals

The CCW program does not allow a legally responsible individual to be reimbursed for providing personal care or similar services to the participant.

A participant's relative may only be reimbursed for providing services under the participant-directed service delivery option. A spouse can also be hired as long as the spouse is not authorized to make financial decisions on behalf of the participant, such as a financial Power of Attorney or bank signing authority. The relative or spouse must not be the legal

guardian of the participant and may not be the designated employer of record. Relatives employed under the participant-directed option must meet the same qualifications required of any other employee delivering that service.

Providers must not employ or contract an individual to provide services to a participant for whom they are legally responsible, even if that individual is otherwise qualified to provide those services.

Room, Board, and Leases

In accordance with 42 CFR 441.310(a)(2), Medicaid funds may not be used to pay for the cost of room and board. Participants who receive services in a provider owned or controlled residential setting are responsible for all room and board costs listed in the lease agreement. The term "room" includes any shelter-type expenses, including all property-related costs such as rental or purchase of real estate, basic furnishings, maintenance, utilities, and related administrative services. The term "board" means three meals per day or any other full nutritional regimen.

The cost of room and board is an allowable expense for respite services provided in an approved assisted living or nursing care facility. The reimbursement rate includes the costs for room and board, so room and board expenses should not be charged to participants who are receiving facility-based respite services.

Providers that deliver services in a provider owned or controlled residential setting must ensure the participant has a lease agreement that affords the same protections against eviction that are afforded to any other person by state law. Providers also must furnish a copy of the lease or resident agreement to the case manager so it can be included in the participant's service plan.

The lease or resident agreement must not include charges for covered waiver services, and must include an itemized list of any additional charges, such as:

- Move in/out fees;
- Security deposits;
- Cable television subscriptions;
- Personal telephone lines;
- Recreational activity fees; and
- Other items of comfort or convenience.

Provider Qualifications

In order to qualify for Wyoming Medicaid reimbursement, CCW services must be delivered by qualified providers and in accordance with all applicable service and provider participation standards. Providers must understand and ensure ongoing compliance with the requirements of the CCW program, the general provider participation standards detailed in Wyoming Medicaid Rules, Chapter 3, and the terms and conditions detailed in the Wyoming Medicaid Provider Agreement. As detailed in CCW Agreement, the HCBS Section has the responsibility to CMS to assure that CCW providers and all employees are qualified for the services they deliver outlined

in 42 CFR §441.302. As such, the HCBS Section may request providers to demonstrate their qualifications, or the qualifications of their staff members, at any time.

Medicaid Enrollment, Provider Agreements, and Wyoming Provider Numbers

All CCW providers must be active, enrolled Medicaid providers. The Patient Protection and Affordable Care Act, 42 U.S.C. § 8001 et seq. (2010) (ACA) requires providers to re-enroll with Medicaid at least every five (5) years.

The initial enrollment process to become a Medicaid provider is conducted by HHS Technologies, a contractor of the Wyoming Department of Health. In order to become enrolled with Medicaid, applicants are required to provide information about their business, including tax and banking information. Additionally, applicants are required to identify the waiver by taxonomy in order to receive waiver payments. The CCW Taxonomy code is 251B00000X. This code is specifically tied to CCW funding. In order for a provider to receive payment for waiver services, they must be enrolled under this taxonomy code. HHS will send a request to the HCBS Certification and Credentialing team to verify that a provider has met waiver qualifications to enroll using the program's taxonomy code.

After a provider has submitted all of the required information and the information has been approved by HHS, a Wyoming provider number is generated and assigned. If the provider delivers services prior to being assigned a Wyoming provider number, they cannot be reimbursed for those services. The Medicaid Provider Agreement, as well as Wyoming Medicaid Rule, Chapter 3 Section 6, specifically states that no Medicaid reimbursement shall be made prior to completing enrollment.

During Medicaid enrollment and re-enrollment, providers are required to sign an updated Medicaid Provider Agreement.

Maintaining Licensure

Many of the services under the CCW program require licensure or approval through other State of Wyoming entities. The Service Index outlines the licensure that is required for CCW services in addition to Medicaid enrollment and CCW certification.

Obtaining and maintaining this licensure is essential to providing CCW services. Entities without the appropriate licensure will be referred to Program Integrity for potential recovery of funds, and will face additional provider credentialing consequences, up to and including termination of their Medicaid Provider Agreement.

More information on licensing requirements specific to facility types can be found at https://health.wyo.gov/aging/hls/facility-types/.

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Certification as a Waiver Provider

In order to provide CCW services, providers must be a certified waiver provider in addition to enrolling as a Medicaid provider.

Initial Certification

Initial certification is a requirement to become a certified CCW provider. Prospective providers must contact the Certification and Credentialing Team at wdh-hcbs-credentialing@wyo.gov to begin the initial certification application process. The Certification Specialist assigned to the initial certification application will provide information regarding signup through the Wyoming Health Provider (WHP) portal and answer any questions the prospective provider has about the application process.

This initial certification process requires the prospective provider to enter basic demographic information, service-related items, upload required documentation, and carefully read and agree to the disclosures within the application.

The initial certification process also requires the prospective provider to describe their business policies and procedures. This may look different from entity to entity, but all prospective providers must be able to describe how they will meet the requirements of the CCW, including honoring participant rights, supporting the participant to access their community, ensuring the participant's freedom to control their schedule and daily activities, and ensuring the participant's freedom to have visitors of their choosing when they choose. Training elements are also included in the initial certification process, and may look different depending on the type of service provided.

After entering the required information, the prospective provider submits the application. The assigned Certification Specialist will review the application and may ask questions or request additional information as needed. Once the submitted application has been approved by the HCBS Section and enrollment is completed, providers are considered certified.

Certification Renewal

In order to qualify for Wyoming Medicaid reimbursement, CCW services must be delivered by qualified providers and in accordance with all applicable service and provider participation standards. Providers must understand and ensure ongoing compliance with the requirements of the CCW program, the general provider participation standards detailed in Wyoming Medicaid Rules, Chapter 3, and the terms and conditions detailed in the Medicaid Provider Agreement. One of the primary ways that providers demonstrate ongoing qualifications is through the certification renewal, also called the recertification process. After a provider becomes initially certified, that provider receives a certification expiration date. The expiration date is the date after which the provider will no longer be able to deliver CCW services unless they have completed the recertification process.

It is important to note that the expiration date is not the "due date" of the recertification. Recertification must be completed prior to the expiration date. If the renewal process is not

completed prior to the certification expiration date, the provider's certification will expire and they will no longer be eligible to receive compensation for services provided to CCW participants. Case managers will not be able to add the provider to service plans, the provider will no longer be listed as an option for participants to choose, and participants served by the provider may be required to transition to new providers.

The recertification process is completed through the WHP portal. At least 120 days prior to the expiration of certification, Division personnel send written notice to the provider via email. This notice includes a link to the WHP portal, specifies the provider expiration date, and provides links and instructions for beginning the recertification process.

Upon login to the WHP portal, the provider will see the recertification in their task list. The provider is responsible for the following:

- Reviewing the demographic and service information the Division has on file for the provider. If there have been any changes to phone numbers, addresses, email addresses, or services, the provider must make the updates as needed.
- Reviewing services and locations to ensure accuracy.
- Uploading the following documents, depending on the service provided:
    - Evidence of Training forms.
    - Additional licensure as required by provider or service type.
    - Roster of staff members, which assists the Division in determining who is responsible for what role, and who is subject to background screenings.
    - Residential agreement form, which demonstrates that residents are afforded the same protections from eviction as any other Wyoming renter per 42 CFR 441.301(c).
    - Residential handbook, which assists the Division in determining that participants rights are ensured per 42 CFR 441.301(c).
    - Updated policies and procedures, which demonstrate that state and federal rules and regulations are observed.
    - Certificate of Good Standing with the State of Wyoming Secretary of State.
- Reviewing and acknowledging disclosures in the WHP.

Once the provider submits the certification renewal application in the WHP, the assigned Certification Specialist will review the submission and contact the provider with any questions or concerns. The Certification Specialist is required to review additional staff documentation to verify that qualifications, background screening, and training requirements are met. The Certification Specialist will also review participant specific information to ensure that the provider is delivering services in accordance with CCW service definitions. The Certification Specialist may ask for additional information, and providers must be responsive to these requests in order to complete the process on time.

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General Responsibilities and Standards

Status as an Independent Contractor

All CCW providers are independent businesses. They are not employees of the State of Wyoming, nor are any individuals employed by the provider. As such, business decisions are the sole responsibility of the provider.

Providers are required to comply with Division rules and regulations, which have the full force and effect of law, in order to be eligible for reimbursement for CCW services. Providers enter into an agreement with the State of Wyoming to abide by state and federal rules and regulations for the CCW program. Providers are responsible for ensuring that services are delivered in accordance with rules and regulations, engaging with the Division regarding training opportunities, updating their email and physical mailing addresses, and responding to Division inquiries in a timely manner.

In addition, as an independent business, each provider has the responsibility to appropriately and adequately oversee their staff members. The provider submits claims for services performed under their business name and associated NPI and/or Wyoming Provider ID Number. Therefore, the provider is responsible for the qualifications and standards of behavior for employees delivering services, billing, and otherwise working for the organization. The following are key responsibilities of each provider.

Employer Responsibilities

HCBS Communications and Training Opportunities

Providers are responsible for carefully reading all communications from the HCBS Section. These communications include emails containing important and timely programmatic information, delivered to the provider's email account from the GovDelivery system. It is important for providers to ensure that their correct email address is on file, and to stay up to date in reading communications sent by the HCBS Section. The HCBS Section also posts important information for CCW providers on the HCBS Section website, including contact information, public notices, current CCW Agreement and approval, and other information. Providers should check in regularly to review new information on the HCBS Section website.

Additionally, the HCBS Section maintains a robust training library on the Training page of the HCBS Section website. The HCBS Section delivers CCW Provider Support Calls on alternating months. These calls offer an opportunity for providers to hear general Division updates, participate in a training topic, and ask questions of HCBS personnel. The calls are also recorded, and slides and notes from each call are posted on the HCBS Section website.

Qualified Staff Members and Professional Scope of Practice

Providers are responsible for ensuring that all claims submitted under its Medicaid Provider Agreement and identification number represent services delivered only by qualified staff

members. Providers must create and maintain detailed personnel files and any other documentation necessary to demonstrate that the individuals delivering services have met all applicable licensure, certification, education, training, experience, and criminal history and background screening requirements for that service. As a part of the CCW assurances required by CMS, the HCBS Section may request demonstration that staff members meet educational requirements at any time.

Providers must also ensure that staff members operate within the limits and scope of practice allowed under the individual's professional licensure or certification and within the limits of the agency's licensure or certification. If providers or the individuals they employ operate outside of their licensure or certification, they will be subject to action by the licensure entity. Additionally, the employing provider may be subject to adverse action, up to and including termination of the Medicaid Provider Agreement, in accordance with Chapter 4 and Chapter 16 of Wyoming Medicaid Rules.

Documentation of Staff Member Qualifications

The provider is responsible for maintaining personnel files that demonstrate staff member qualifications in accordance with Chapter 3 of Wyoming Medicaid Rules, which addresses provider participation and document retention. The Division does not store or maintain documentation related to personnel files. Demonstration of employee qualifications must be made available to the Division during certification renewal and upon request.

Additionally, some licensure is renewed by the licensing entity on an annual basis; the provider is responsible for obtaining and uploading this information in the WHP portal with any new or updated licensure. It is important to note that licensure tasks will populate on a more frequent basis within the WHP portal than certification renewal tasks. Providers must ensure that all tasks are completed in a timely manner to ensure the ongoing qualifications of staff.

Background Screening Requirements

A criminal history and background screening must be conducted for employees, contractors, and volunteers who may have unsupervised direct contact with participants in the regular course of delivering the following CCW services:

- Adult Day Services (Health Model);
- Assisted Living Facility Services;
- Case Management;
- Home Health Aide;
- Personal Support Services;
- Respite; and
- Skilled Nursing.

As of April 1, 2023, the following services will also be subject to background screening requirements:

- Adult Day Services (Social Model);

- Homemaker Services;
- Independent Living Services;
- Transition Intensive Case Management Services; and
- Transition Setup Services

Background screenings must be completed upon initial employment. Documentation of background screenings must be maintained by the provider for all staff who qualify for screenings. This information will be requested as a part of recertification with the CCW program, and may be requested at other times by HCBS staff. The background screening includes the following elements, which can be found on the CCW Providers and Case Managers page of the HCBS Section website, under the *CCW Background Screening Resources* toggle.

- Office of Inspector General Exclusions Database Search:
    - This element ensures that individuals have not been convicted of Medicaid fraud. The list is maintained by the United States Department of Health and Human Services, Office of Inspector General. In order to conduct this search, visit https://exclusions.oig.hhs.gov/. To document a successful search, please print and retain a screenshot of the search performed with no results listed.
- United States Department of Justice, National Sex Offender Public Website Search
    - This element provides information to the public on the whereabouts of registered sex offenders. In order to conduct this search, visit https://www.nsopw.gov/.
- DCI/FBI Background Screening:
    - This element ensures that individuals have not been convicted of a qualifying barrier crime locally or nationally. This screening includes a Wyoming Division of Criminal Investigation (DCI), Western Identification Network, and Federal Bureau of Investigation (FBI) Check.
    - As of April 1, 2023, criminal background screening requirements will change. Name and social security number based screenings will be accepted for background checks. These results must be obtained by the provider, and will not be submitted through DCI.
- Department of Family Services Central Registry Check:
    - This element ensures that individuals do not have a substantiation of abuse or neglect from the Wyoming Department of Family Services (DFS). This check is conducted through the DFS Abuse and Neglect Central Registry. In order to conduct this check, visit https://dfs.wyo.gov/about/central-registry/.

Background screenings must confirm that the individual has not been excluded from federally funded healthcare programs, is not currently under investigation for or has not been substantiated for abuse or neglect, and has not been convicted of, has not pleaded "no contest" to, and does not have a pending deferred prosecution of any crimes listed in Chapter 2 or Chapter 4 of Wyoming Title 6, which includes but is not limited to:

- Homicide (W.S. 6-2-101);
- Kidnapping (W.S. 6-2-201);
- Sexual assault (W.S. 6-2-301);

- Robbery and Blackmail (W.S. 6-2-401);
- Assault and Battery (W.S. 6-2-501);
- Bigamy (W.S. 6-4-401);
- Incest (W.S. 6-4-402);
- Abandoning or endangering children (W.S. 6-4-403);
- Violation of an order of protection (W.S. 6-4-404); and,
- Human trafficking (W.S. 6-2-701).

Providers may choose to allow a staff member to provide services on a provisional basis following the submission of the background screening, as long as barrier crimes or relevant criminal records are not disclosed on the application, until the individual staff member is cleared through successful background screenings. Providers must retain a signed attestation acknowledging that the individual:

- Has not been convicted of a barrier crime;
- Has not pleaded "no contest" to a barrier crime;
- Does not have a pending or deferred prosecution of any barrier crime; and,
- Has not been substantiated against by the Wyoming Department of Family Services for abuse and/or neglect.

If the background screening is not successful, the provider must immediately disallow the individual from providing or billing for services.

Circumstances can change over time; therefore, effective April 1, 2023, a subsequent background screening will be required every five years for all individuals who are required to undergo an initial background screening. The five years is calculated based on the date the last background screening results were issued. Additionally, any provider that hires an individual or entity listed on the OIG Exclusions database may be subject to civil monetary penalties. To avoid these penalties, the OIG strongly encourages providers to routinely check the database to ensure that new hires and current employees are not listed. Effective April 1, 2023, providers will be required to conduct routine OIG Exclusions Database screenings.

The Provider Credentialing Team will review subsequent background screenings during provider certification renewals. Documentation that demonstrates that these screenings have occurred can be requested by the HCBS Section at any time.

Ensure Appropriate Training to Meet Participant Needs

The provider must ensure that any individual employed, including any subcontractors, receive sufficient orientation, training, and oversight to have the skills necessary to meet the needs of participants and be able to respond to emergencies.

Documentation of Services

CCW providers are responsible for the accuracy of the claims they submit for reimbursement. The Division conducts audits of provider claims through an on-site evaluation or desk review.

Providers must submit records requested by the Division or any other investigative authority in accordance with Chapters 3 and 16 of Wyoming Medicaid Rules.

CCW providers must create and maintain sufficient documentation to substantiate the claims submitted for Wyoming Medicaid reimbursement, and demonstrate that the services were delivered in accordance with Division requirements. Service documentation can go by several different names depending on the type of service and professional licensure standards. For the purposes of Medicaid, the required elements of documentation are outlined in Chapter 3 of Wyoming Medicaid Rules, and in Section 5(l) and 5(q) of the Medicaid Provider Agreement. At a minimum, provider documentation must include:

- The name of the participant served;
- A list or description of the specific services provided;
- The date(s) and time(s) of service delivery;
- The name(s) and title(s) of those who delivered the services; and
- Any signatures or other documentation necessary to verify that the services were actually rendered.

Service documentation must be retained for a period of at least six (6) years from the date(s) of service listed on the claim, or as otherwise required by Chapter 3 of Wyoming Medicaid Rules.

Service Authorization and Reimbursement

The Division's service authorization and reimbursement policies are designed to assure its effective and efficient administration of the Wyoming Medicaid program, its good stewardship of public funds, and the overall integrity of the CCW program. These policies ensure that payment is made only for those services which were delivered in accordance with the Division's established service coverage and quality standards.

The CCW program uses a fee-for-service reimbursement structure. The maximum reimbursement amounts for waiver services are established by the Division, and each service is reimbursed separately according to an established fee schedule, which can be viewed on the Services Definitions and Rates page of the HCBS Section website.

Rate Determination Methods

The Division uses a cost-informed provider reimbursement rate determination methodology, which is designed to reflect the scope of the covered service, recognize reasonable and necessary provider costs, and increase transparency. The information contained within the Provider Rate Study utilizes information about actual expenses from CCW providers. Providers are strongly encouraged to participate in these cost studies in order to ensure their costs are considered when rates and rate methodologies are under review. For more information on this process, please visit the Public Notices, Regulatory Documents, and Reports page of the HCBS Section website, and refer to the CCW State Fiscal Year 2022 Provider Rate Study.

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Billing for Waiver Services

In order to bill for and be paid for CCW services, providers must successfully complete and submit electronic claims for service. Details about billing for services and extensive training and support for billing can be found at the Wyoming Medicaid website. This site includes detailed tutorials and information regarding the use of the required billing systems.

Benefit Management System

All Wyoming Medicaid claims are processed through the Benefit Management System (BMS). Claims for services that are subject to electronic visit verification must be submitted to BMS through Carebridge; all other service claims must be submitted directly to BMS. BMS is administered through the contractor CNSI; CNSI representatives provide support to providers in submitting claims, troubleshooting payment issues. and general assistance. To contact CNSI, email wyprovideroutreach@cns-inc.com or call (888) 996-6223.

Documentation to Support Claims

Generally, Chapter 3 of Wyoming Medicaid Rules outlines the requirements for payment and submission of claims by providers. A number of requirements are included in that Chapter, including but not limited to:

- Service may require prior authorization: All CCW services require prior authorization (PA).
- All claims submitted must include the required fields.
- Providers must retain documentation to support the claim submitted. This service documentation also must be provided to the Division upon request.
- Providers are required to accept payment in full from Medicaid, and to not seek additional payment for the services rendered. This requirement is outlined in Chapter 3, Section 12(b)

Additionally, some CCW-specific billing requirements can be found in Chapter 3 and in the CCW Agreement.

- As established in 42 CFR 447.45(f)(1)(iii), providers are only allowed to bill for one direct service to a participant at a time. If more than one staff member is needed, such as to assist with transfers, the provider cannot bill the service twice during that time.
- Rounding Rules
    - The initial 15 minute unit of a service must be rounded down if it is under 15 minutes, as anything less than 15 minutes of service does not qualify for payment. Typical rounding rules apply (7.59 minutes must be rounded down, 8 or more minutes may be rounded up) for subsequent units.

Electronic Visit Verification

In 2016, Congress passed the 21st Century Cures Act. As a part of that federal legislation, all state Medicaid Programs are required to implement an electronic visit verification (EVV) system for services that are home health or personal care-related services. This federal requirement applies to the CCW, and the services in Table 6 must be billed through EVV:

Table 6
EVV Qualifying Services

Service Code	Service Name
S5125	Personal Support Services (Agency based)
T1004	Home Health Aide
T1002	Skilled Nursing (RN)
T1003	Skilled Nursing (LPN)
S5150	Respite

The Department of Health contracts with Carebridge, the vendor chosen for the Wyoming EVV system through the competitive bid process. If a provider delivers any of the services listed in Table 6, they are required to work within Carebridge to set up appointments, clock in and out of services, and submit this information for billing purposes.

It is acceptable for a provider to use a third-party system other than Carebridge, as long as the third-party system fulfills the requirements of the 21st Century Cures Act, and the provider and third-party system can transfer information to Carebridge through system integration. Even if the provider elects to work with a third-party system, all provider claims for the services listed in the table above must be submitted through Carebridge for billing.

For more information on Carebridge or EVV, visit https://www.carebridgehealth.com/wyevv.

Obligations to Participants

In addition to responsibility over employee qualifications and conduct, the provider also has a responsibility to the participant receiving services. The following information outlines the obligations providers have to participants.

Implement and Follow the Service Plan

The provider is a member of the plan of care team, and must actively participate in developing and maintaining service plans, to the extent that the participant wishes them to participate. Providers are required to follow the service plan, and if there are challenges or obstacles to delivering services in accordance with the service plan, the provider is responsible for requesting that the plan of care team address those issues. The provider must maintain documentation to demonstrate that sufficient staff provided services, supports, and supervision to meet the needs of each participant in accordance with each participant's service plan and according to the Service Index.

Providers must maintain adequate administrative and staffing resources and emergency backup systems in order to render services in accordance with all state and federal requirements and as described and agreed to in the participant's service plan. Providers must make all reasonable efforts to avoid disruptions of service delivery that would jeopardize the participant's health and welfare. Providers must establish internal policies and procedures for responding to emergencies and create backup plans and strategies to ensure continuity of services.

Person-Centered Planning

Providers are required to deliver person-centered services through the CCW program. Person-centered services stem from person-centered planning, which is an ongoing process used to help people with disabilities plan for their future. In person-centered planning, the plan of care team focuses on the participant and that person's vision of what they want their life to be. The plan of care team identifies opportunities for the participant to develop personal relationships, participate in their community, increase control over their own life, and develop or maintain the skills and abilities needed to achieve these goals. Person-centered services include several elements, which are described below.

- **Support and Promote Health, Safety, and Well-Being**
  Providers are required to protect participants from abuse, neglect, mistreatment, intimidation, and exploitation in accordance with W.S. § 35-20-103(a). This provision requires any person or agency who has reasonable cause to believe that a vulnerable adult is being or has been subject to such actions to report appropriately. Providers must develop a process for detecting and preventing abuse, neglect, exploitation, and intimidation, and respond to allegations of abuse, neglect, exploitation, and intimidation in accordance with state and federal rules and regulations. Further details regarding reporting requirements and processes can be found in Section 6 of this Manual.
- **Treat Participants with Consideration, Respect, and Dignity**
  Providers must ensure that every participant for whom they provide services is treated as an individual with inherent worth. Providers are expected to encourage participants to express their wishes, desires, and needs on a regular basis throughout service planning and delivery. Additionally, providers are expected to honor participant preferences, interests, and goals, and to support participants with daily opportunities to make choices and participate in decision making. Providers must facilitate activities that are meaningful and functional for each participant, and deliver services aimed at maximizing the growth and development of each participant in order to increase community participation and citizenship.
- **Accept Referrals Responsibly**
  Before providing services to a participant, the provider must gather and review referral information regarding the participant so, to the greatest extent possible, the provider is aware of the participant's preferences, strengths, and needs. The provider must use this information to make a determination as to whether the provider is capable of providing services to meet the participant's needs. In order to make a responsible and informed decision, the provider must consider whether their organization has the capacity, commitment, and resources necessary to provide support to the participant. The provider should not serve a participant if the provider cannot reasonably assure the

participant, legally authorized representative, and case manager that it has the ability to meet the participant's needs. This evaluation should occur prior to accepting the electronic referral in the WHP portal.

An important element to consider when reviewing referrals is whether the provider can deliver requested services with modifications to the referrals. Requesting modifications to referrals can assist the provider in determining if the participant is open to flexibility on days or times the service has been requested. If the provider agrees to deliver the services without modification to the referral, the provider is expected to provide those services on the days and time specified in the accepted referral. If the provider is unable to deliver the services as specified due to changes within the organization, the provider must work with the case manager and participant to determine if it is acceptable to the participant to receive services outside of the specifications of the referral. The participant has the discretion to choose a new provider if the current provider is unable to meet their needs. Similarly, providers are responsible for determining if they can meet the participant's needs as presented, and to update the participant and case manager promptly if they are unable to do so. If the provider is unable to meet the participant's needs, they are required to give 30-day notice to the participant.

Providers must accept or decline a participant referral based on the provider's ability and capacity to provide the service, and must not discriminate based on race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression, or disability.

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Section 3. Case Management Agency Administration

A case management agency may be one person who is a case manager or an organization that hires case managers; however, the agency itself must be enrolled as a Wyoming Medicaid provider and is subject to the provisions of the Medicaid Provider Agreement. The case management agency retains the responsibility for the oversight of the services it provides and for ensuring those services are delivered by qualified case managers who have received adequate training and supervision to conduct the required case management activities. The case management agency is responsible for verifying and maintaining documentation that employed or contracted case managers meet all case management qualifications.

The case management agency is responsible for managing the performance of case managers employed by or contracted with the agency, and must have internal mechanisms for assessing and managing the performance of each case manager. Should the case management agency fail to address case manager performance concerns to the Division's satisfaction, the Division may provide technical assistance, or issue corrective or adverse action, up to and including termination of the case manager's status as a CCW program case manager.

A representative from each case management agency must complete the Case Management Agency training; this requirement is in addition to agency responsibility to ensure individual case managers complete training as outlined below.

Required Written Procedures

Case management agencies must develop written procedures sufficient to execute case management services according to the requirements established in the CCW Agreement and Division policy. Written procedures should include:

- Assessment;
- Service plan development;
- Referral and related activities;
- Service plan monitoring;
- Authorization of services; and
- Service denials, reductions, discontinuations, and waiver terminations.

Case Manager Qualifications

In order to qualify as a case manager, the case manager must be employed or contracted by a qualified, certified case management agency. The Division may request evidence of case manager qualifications at any time, and services delivered by an unqualified case manager may be subject to payment recovery.

Education and Experience

Case managers must meet the following education and experience requirements:

- A master's degree from an accredited college or university in human services, social services, or a related field of study;
- A bachelor's degree from an accredited college or university in human services, social services, or a related field of study and one (1) year of related work experience in human or social services; or
- An associate's degree from an accredited college or university in human services, social services, or a related field of study and four (4) years of related work experience in human or social services.

A case manager who was employed by a case management agency prior to July 1, 2016 may continue to provide case management services without meeting the above criteria as long as the case manager has a high school diploma or high school equivalency certificate and six (6) years of experience as a case manager.

Case Manager Training

Prior to delivering case management services, the case manager must demonstrate the requisite knowledge, skills, and abilities through successful completion of the Division's approved case management training curriculum.

Case managers must complete the training and Evidence of Training form for each required module prior to providing case management services independently. This demonstration of understanding is important for each case manager to complete, as it is documentation and evidence that the case manager has reviewed and understood the training provided. Additional training required by the case management agency should also be documented.

Case managers must receive refresher training annually. A case manager may be required to to retake any training at the Division's discretion. Case managers must attend any mandatory training required by the Wyoming Department of Health or Division of Healthcare Financing.

The case management agency is responsible for maintaining documentation of all case manager training, to include at minimum the date and title or topic of the training.

Conflict of Interest

Under federal regulation, case managers must be free of conflicts of interest. Specifically, case management services cannot be conducted by an individual or entity that has a financial interest in, or is employed by, a provider listed on the participant's service plan.

To ensure compliance with this requirement, the Division has established the following conflict of interest standards:

- The case manager must not be related by blood or marriage to the participant or to any individual paid to provide Medicaid HCBS to the participant.
- The case manager must not share a residence with the participant or with any individual paid to provide Medicaid HCBS to the participant.

- The case manager or case management agency must not be financially responsible for the participant.
- The case manager or case management agency must not be empowered to make financial or health-related decisions on behalf of the participant. Financial and health-related decisions are the responsibility of the participant and legally authorized representative, if relevant. Case managers coordinate care needed by the participant, but are not authorized to make financial or health-related decisions.
- The case manager or case management agency must not own, operate, be employed by, or have a financial interest in any entity that is paid to provide Medicaid HCBS to the participant. Financial interest includes a direct or indirect ownership or investment interest or any direct or indirect compensation arrangement.
- The case manager must not provide or bill for targeted case management services while also billing for CCW case management services for the same participant.

Should a conflict arise, it is the case manager's duty to inform the participant and assist the participant in finding a new case manager, case management agency, or provider agency as necessary to eliminate potential conflicts of interest. It is also important to note that backup case managers may be from the same agency as the day to day case manager, but are also required to operate in a conflict-free manner. The agency for which the backup case manager works must ensure that all conflict of interest standards are met.

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Section 4. Service Planning and Delivery

Before a participant can receive services through the CCW, they must be determined eligible for the program. Eligibility begins with an application, determination of Wyoming Medicaid eligibility, and a level of care assessment. For more information on participant eligibility, please refer to the CCW Case Management Manual, which is located on the CCW Providers and Case Managers page of the HCBS Section website.

Once eligibility has been determined, the participant will need a service plan. The service plan is the guiding document that explains what services should look like, how they should be delivered, and how they meet the specific needs of the participant. The service plan must be specific to the participant, and must:

- Support and promote the health and welfare of the participant;
- Identify and promote the participant's strengths;
- Promote the participant's own goals, needs, and preferences;
- Address the participant's assessed needs; and
- Include a plan to mitigate identified risks.

Prior Authorization Requirements

All CCW services must be prior authorized by the Division. This prior authorization, often referred to as a PA, helps to ensure compliance with federal regulation. Most importantly, it ensures that all services are delivered under a written, person-centered service plan, which is subject to Division review. Prior authorization also ensures that waiver services are delivered by a qualified provider and in a manner that does not duplicate other services provided under the CCW, Wyoming Medicaid State Plan, or other funding sources.

After the participant's case manager submits the service plan through the Electronic Medicaid Waiver System (EMWS), the service plan is screened through an automated review process. Once reviewed, the service plan is finalized in EMWS. EMWS then exchanges data with the Benefit Management System (BMS) , which is the system that issues prior authorizations and processes claims. Providers are notified of waiver service prior authorization via the WHP portal.

Although prior authorization is required for reimbursement, a prior authorization alone does not guarantee payment. In addition to being prior authorized, the service must:

- Be reasonable in amount, scope, and duration according to the assessed needs of the participant;
- Support the participant in community life;
- Be necessary to avoid institutionalization:
- Be delivered in accordance with the participant's service plan;
- Be consistent with the definition of the service; and
- Be delivered by a qualified provider.

Payment can only be made if the participant is eligible for services and the provider is enrolled as a qualified provider on the date the services are delivered. All claims for reimbursement must be submitted in accordance with the Division's established billing procedures.

In addition to CCW services, the service plan should include any Wyoming Medicaid State Plan services that the participant may need, as well as other non-Medicaid community and natural resources that the participant can utilize.

As case managers add services during the service plan development process, a referral task will be created on the provider's task list in the WHP portal. This task will require an exchange between the case manager and provider to assure services can be provided in accordance with the participant's needs. A provider has two days to take action on the referral.

Plan of Care Team

The service plan is developed and, if necessary, modified by the plan of care team, which includes the participant, the legally authorized representative if applicable, the case manager, providers, and any other natural supports or medical personnel that the participant wishes to include. It is important for the participant to define who they want to be involved in the planning process, and the extent to which providers participate in the process. While some providers, such as Home Delivered Meals or Personal Emergency Response System (PERS) providers, may not be able to participate in-person, it is important for providers who deliver direct services to be involved in the planning process.

The Division encourages providers to work with participants to ensure their needs are being met. If a participant feels that additional support is needed, the provider must contact the participant's case manager and work through those concerns as a team. The case manager should modify a participant's service plan if the participant's needs change.

Service Plan Development

The participant's case manager is responsible for facilitating plan of care team meetings, coordinating service plan development, and ensuring that participants are driving the content of the service plan. Case managers are responsible for educating participants about rights, including:

- The right to choose between nursing facility and community-based services;
- The right to choose the CCW services they would like to receive;
- The right to choose community-based setting options, including the right to receive services in a non-disability specific setting;
- The right to choose to receive services from any willing and qualified provider; and,
- The option to manage their support through participant-directed services.

The case manager's role in supporting the participant's choice of providers is an important one. Case managers must provide a list of all enrolled providers serving the participant's county of residence in order to ensure the participant has informed choice regarding their service options.

Case managers are expected to support participants in engaging in and leading the service plan development process to the maximum extent possible. This is accomplished by:

- Encouraging the participant to engage with friends, family members, professionals, and other individuals he or she trusts to explore and understand issues and choices;
- Allowing and supporting the participant to ask questions;
- Enabling and supporting participant communication and self-advocacy; and,
- Offering explanations in a language or manner that the participant understands.

The participant must provide informed consent to the service plan, documented in writing.

Once the service plan is finalized, the case manager distributes the service plan to all individuals who are responsible for its implementation. The service plan contains information necessary for each provider to deliver and claim reimbursement for services, while also assuring the privacy of the participant. For example, the personal emergency response system (PERS) provider's version of the service plan includes relevant responsibilities and service descriptions for the PERS service, but does not include details of the participant's personal care routine. Providers should retain copies of the service plan and reference the plan for service delivery. Additionally, providers should retain the service plan as necessary to support claims filing and documentation in accordance with Chapter 3 of Wyoming Medicaid Rules.

Provider Role in Service Plan Development

Participants have the authority to determine who may be involved in the person-centered planning process, and to what extent their service providers may contribute to that process. Regardless of the degree to which the provider is involved in the planning process, the provider still plays an important role. This role includes:

- Accepting or rejecting referrals for services after a careful evaluation of the resources, expertise, and capacity needed to deliver the services as described;
- Thoughtfully considering the specific details included in the referral;
- Providing any requested documentation necessary to demonstrate compliance with home and community-based setting requirements, if applicable; and
- Cooperating with the case manager to develop a plan for restrictive intervention, if necessary.

By accepting a referral for CCW services, the provider agrees to and accepts the responsibility of delivering services according to the participant's service plan.

Service Plan Review and Modifications

The service plan must be reviewed and updated at least annually. However, if the participant requests a change, or if there is a significant change in the participant's circumstances, a plan of care team meeting should be held and the service plan should be updated in order to address these changes.

The case manager is responsible for identifying necessary modifications, and must document changes in the participant's condition or circumstances. The case manager is responsible for making modifications to the service plan, and the services and supports are coordinated in accordance with the initial service plan development and referral procedures. Providers must carefully review these modifications to ensure that they are able to provide services as outlined in the updated service plan.

Utilization Management Review for Skilled Nursing

The Division's Utilization Management (UM) vendor requires an additional approval for Skilled Nursing services.

The UM vendor uses trained reviewers with clinical expertise to ensure that there is documentation demonstrating how the nursing service fits within the service definition. The provider agency or case manager may be required to submit additional documentation during this process. The case manager must upload the results of the UM vendor's review into EMWS in order to finalize the service plan and receive prior authorization of Skilled Nursing services.

Service Modification or Termination

Participants have the right to modify or terminate their services at any time. Participants are required to inform their case manager about their desire to make changes to their services or providers. The case manager is then responsible for coordinating next steps, including a transition to a new provider if appropriate. Providers must work with the participant, case manager, and plan of care team to ensure the participant's change in services or providers is successful.

Provider Termination of Services

A provider may decide to discontinue services for many reasons, including:

- The provider is unable deliver services in accordance with the participant's service plan;
- The provider is unable to serve the participant in accordance with program requirements;
- The provider would be required to deliver a level of care outside of the scope of practice defined by the provider's license; and
- Other reasons that are not discriminatory in nature.

If a provider must terminate services, the provider is responsible for providing at least 30-day notice to the participant, the case manager, and legally authorized representative, if applicable. Notice should be provided in written format, and specify the date the service will end. This time period allows time for the participant and case manager to arrange for the participant to transition to a new provider. Providers should retain evidence that notification was provided, and be prepared to share it with the Division upon request. During this time, the current provider must continue to provide the agreed upon services, and work with the case manager to provide the information necessary for the participant's successful transition. If the

participant is transitioning to another case manager, please refer to the CCW Case Management Manual for information regarding this transition.

In rare instances, there may be issues that put the health or safety of the participant or staff members in jeopardy. In such circumstances, the provider may terminate services without the required 30-day notice. If a provider seeks an exemption from the 30-day notice requirement, the provider must contact the Division for prior approval. Health and safety concerns rising to this level should be reported to the appropriate investigative authorities, such as law enforcement and the Wyoming Department of Family Services. Additionally, health and safety issues prompting such a request must be reported to the Division as an incident. A provider cannot seek an exemption from the 30-day notice requirement for provider convenience.

Section 5. HCBS Final Rule: Services and Settings

Home and Community-Based Setting Requirements

A fundamental aspect of CCW services is that the *services* and the *settings* must be home and community-based in nature. When referencing home and community-based services, the subject is the actual services that are being provided. Home-delivered meals, respite, and personal support services are all examples of home and community-based *services*. Home and community-based *service settings* are the settings in which the services are provided. As stated in Section 1, in order for a setting to be home and community-based, it must meet specific state and federal requirements.

In 2014, CMS issued guidance regarding home and community-based service settings, also known as the Final Settings Rule. This guidance is located at 42 CFR § 441.301(c)(4). CMS recognized that steps needed to be taken in order to support individuals in the community. One step was to provide clear definitions and regulation regarding the types of settings that truly uphold the goals of home and community-based programs, which would then qualify for federal funding for HCBS. In addition to clearly defining the characteristics of settings that would be considered home and community-based in nature, CMS wanted to ensure that the settings supported people to integrate into their respective communities, develop and maintain relationships with others, and control decisions within their daily lives.

CMS has defined settings that *are not* considered home and community-based in nature. These settings include:

- Any setting that is located in a building that is also publicly or privately operated facility and provides inpatient institutional treatment;
- Any setting that is in a building on the grounds of, or immediately adjacent to, a public institution; or
- Any other setting that has the effect of isolating individuals receiving home and community-based services from people who don't receive home and community-based services. Requiring participants to spend their free time with roommates in a congregate living setting rather than participating in community activities with friends or family is an example of how participants could be isolated.

CMS has also established characteristics of settings that *are* considered home and community-based in nature. In order for a setting to be considered home and community-based:

- It must be integrated and support full community access.
- It must be selected by the participant, who has other options from which to choose, including settings that are not disability specific.
- The services received in the setting must facilitate opportunities for participants to advocate for themselves and participate in lifelong learning.
- When the participant is in the setting, their rights to privacy, dignity, respect, and freedom from coercion and restraint must be ensured.

- While in the setting, participants must have autonomy and independence in making life choices, including those related to daily and recreational activities, physical environment, with whom they interact, the services and supports they receive, and who provides those supports and services.
- Participants should be encouraged to have visitors when they choose. Providers and participants should work together to identify how participants can have visitors in a way that does not infringe on the rights of others, and considers the wishes and needs of everyone in the setting.

Provider Owned and Controlled Residential Settings

In addition to ensuring that both services and settings are home and community-based in nature, providers that deliver services in settings that it owns or controls must meet additional obligations in order to be in compliance with CMS regulations.

Provider owned and operated settings can take many forms. Settings that are owned or co-owned by the provider are easily identified. However, there are other situations that may be more difficult to classify. If a provider is unsure if a setting is provider owned or operated, they should contact the Division for further assistance. Current examples of provider owned or controlled settings include Assisted Living Facilities (ALFs), where individuals reside on a property owned by the ALF.

According to the Final Settings Rule, these provider owned or controlled settings must be in compliance with additional required standards. The standards include the following:

- The participant must have an enforceable lease agreement that provides protections from eviction and meets landlord tenant law in Wyoming, or must have a residency or other written agreement that ensures the participant's rights in the eviction and appeals process, and provides participant protections comparable to those provided under the jurisdiction's landlord tenant law.
- The participant must have privacy in their sleeping or living unit, or have a choice of roommates.
- Units must have lockable entrance doors, with only the participant and appropriate staff having keys to doors as needed.
- Participants must have the freedom to furnish and decorate their sleeping or living units within the lease agreement.
- Participants must have freedom and support to control their schedules and activities, and have access to food at any time.
- Participants must have the ability to have visitors at any time.
- The setting must be physically accessible to the participant.

Participant Rights, Rights Restrictions, and Restraints

Another element of the Final Settings Rule, specifically 42 CFR § 441.301(c)(4), relates to participant rights. This CFR specifies that participants have certain rights, including the rights to:

- Full access to the greater community;
- Privacy;
- Dignity;
- Respect
- Independence in making life choices;
- Freedom to control their own schedules and activities;
- Freedom from coercion;
- Freedom from restraint;
- Access to food; and
- Ability to have visitors of their choosing at any time.

As stated previously, all CCW services must be delivered in a manner that reflects and honors the rights of participants. In accordance with federal regulation, the Division prohibits providers from violating a participant's rights.

Restrictive Interventions

In some situations, restrictive interventions may be necessary in order for the participant to safely receive CCW services. Restrictive interventions are only permitted in the delivery of assisted living facility services, adult day services (health model), and respite services delivered in an assisted living or nursing facility. A restrictive intervention is any action or procedure that limits or restricts the participant's:

- Movement;
- Privacy;
- Full access to the greater community;
- Access to other individuals, locations, or activities;
- Access to food;
- Freedom to control their own schedules, activities, and resources;
- Independence in making life choices; and
- Ability to have visitors of their choosing at any time.

If there is a need for a restrictive intervention, that need must be identified during the person-centered planning process. During this process, the participant, the case manager, and the provider are responsible for developing specific guidance in the service plan that explains how the restrictive intervention will be performed, and appropriate limitations to the restrictive intervention. Prior to implementing a plan that includes a restrictive intervention, the case manager must document the following information in the service plan:

- The participant's assessed health and safety need and how the restriction addresses that specific need. The service plan should also explain how the provider should perform the restriction of that right.
- Less restrictive alternatives and positive supports that have been tried in the past. The service plan must also address why these alternatives were not successful.
- How the restriction is proportional to the participant's assessed need.
- Ongoing data that will be used to measure the effectiveness of the restriction.

- Established time limits for regular review of the restriction.
- Assurance that interventions and supports will not cause harm to the participant.
- The participant's informed consent.

While the CCW program does allow for the restriction of certain rights, blanket restrictions put in place across an entire setting are prohibited. Restrictive interventions must be imposed on an individual basis. For example, an ALF cannot impose a blanket restriction on every participant's right to have a lock and key for their bedroom door. This type of restriction can only be implemented based on a participant's individually assessed needs. Similarly, an ALF that has a locked unit for participants with memory impairments must document a rights restriction for each participant who has that assessed need.

The right to dignity, respect, settings that are physically accessible, and freedom from coercion may never be restricted. Additionally, a participant's rights can never be restricted for provider convenience. Rights are not privileges, and participants must not be required to earn them through good behavior.

If the participant agrees to a restrictive intervention, the case manager must obtain informed consent, and provide documentation of that consent to the provider. Case managers must facilitate a review of restrictive interventions at least every six months. This review must be conducted in person, and include follow-up with the provider. The provider should be regularly evaluating the effectiveness of the restrictive intervention, and must coordinate with the case manager to update the service plan every six months and as needed.

Participants have the right to refuse restrictive interventions. If the provider is unable or unwilling to provide services to the participant without restrictive interventions, the case manager is responsible for discussing this matter with the participant. The case manager is required to explain the options available to the participant, and assist them in finding a new provider or other service options, if necessary.

Restrictive interventions may not be imposed as a means of coercion, discipline, convenience, or retaliation by the provider, family members, or others. Again, the right to dignity, respect, and freedom from coercion may never be infringed upon by restrictive interventions. Providers must report known or suspected unauthorized use or the misapplication of restrictive interventions as an incident. Further information regarding incident reporting can be found in Section 6 of this document.

Restraints

In limited situations, it may be necessary to restrain a participant when they pose a significant danger to themselves or others. Physical, chemical, and mechanical restraints are permitted during the provision of ALF services or respite services delivered in assisted living or nursing facilities. However, the use of restraint must follow specific requirements. Restraints must meet the standards established by the licensing agency, be ordered by a physician, and be necessary to address the participant's medical symptoms. As such, the nature of a restraint is

expected to be short-term, in response to a specific event or identified behavior, and never performed for the purpose of discipline or convenience. Additionally, the use of restraints must be indicated in the participant's service plan. Only the least restrictive restraint should be implemented, and the provider must continue to support the participant's physical, health, and emotional needs.

ALFs and nursing care facilities must comply with all protocols, practices, record keeping, and staff education and training requirements for the application of restraints in accordance with Chapter 11 of the Aging Division Rules for Program Administration of Nursing Care Facilities and Chapter 12 of the Aging Division Rules for Program Administration of Assisted Living Facilities.

Providers must identify the unauthorized use or misapplication of restraints, and must report any known or suspected use of restraints or the misapplication of restraints as an incident. More information regarding incident reporting can be found in Section 6 of this document.

Seclusion

Seclusion is a type of restrictive intervention that includes the involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from leaving or having contact with others. The use of seclusion for any reason is prohibited in the CCW program. Providers must report any known or suspected use of seclusion as an incident. Further information regarding incident reporting can be found in Section 6 of this document.

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Section 6. Provider Support and Oversight

The Division supports a culture of participant safety and well-being, and ensures provider compliance with state and federal rules and regulations in several ways. This Section outlines the incident and complaint process, how incidents and complaints are resolved, the provider's responsibilities regarding incidents and complaints, and provider supports such as technical assistance, corrective action, and adverse action.

Reporting Critical Incidents

Incidents are events that happen during the provision of services that require a specific response from a provider and case manager. These events may happen as a result of an accident, noncompliance with rules and regulations, illness, or other challenge. Every provider has the responsibility to report incidents via the electronic reporting process. Providers cannot delegate incident reporting responsibilities to the case manager, or vice versa. Division personnel review the incident, ensure that provider and case manager responses were in compliance with rules and regulations, and conduct appropriate follow-up as necessary.

Mandatory Reporting

According to Wyoming law, everyone must report the suspected abuse, neglect, or exploitation of children or vulnerable adults to the Department of Family Services if they have reasonable cause to believe that it may be occurring. However, reporting an incident to DFS does not replace the reporting that is required by the Division. More information related to mandatory reporting requirements can be found at https://dfs.wyo.gov/i-need-to-report/abuse-neglect-exploitation/.

Incidents Defined

First and foremost, providers are responsible for the safety and well-being of the participants they support. Any issue that requires immediate medical, health, or law enforcement intervention must be addressed by contacting the appropriate emergency responders. Providers are required to report criminal activity to law enforcement; report suspected abuse or neglect to the local DFS office and law enforcement, and call an ambulance in the case of a medical emergency. In an emergency, do not wait to contact these entities. An incident can be filed after attending to the health and safety concerns of participants.

Incidents can range in type and severity. Even if an incident may not appear to be severe, providers are required to report identified incidents to the Division.

Table 2 outlines critical incidents that must be reported to the Division. Critical incidents must be reported immediately after assuring the participant's health and safety or, in the event of an unexpected death, immediately after being notified of the incident.

Table 2
Critical Incident Definitions

Incident	Definition
Abuse	The intentional or reckless infliction of injury or physical or emotional harm. This category may include physical abuse, verbal abuse, emotional abuse, sexual abuse, and intimidation.
Neglect	The deprivation of, or failure to provide, the minimum food, shelter, clothing, supervision, physical and mental health care, prescribed medication, or other care as necessary to maintain the participant's life or health, or which may result in a life-threatening situation. This category may include self-neglect, neglect by a service provider, or neglect by family member or other natural support
Exploitation	Fraudulent, unauthorized, or improper acts or processes of an individual who uses the resources of the participant for monetary or personal benefit, profit, or gain or that results in depriving the participant of their rightful access to, or use of, benefits, resources, belongings, or assets. This category may include financial exploitation, sexual exploitation, prescription drug theft/diversion, or other material exploitation.
Unexpected Death	Death of a participant. This cateogry may include death as a result of an unexpected natural cause, illness, or disease; death as a result of neglect; death as a result of trauma inflicted by another person; death as a result of a medication error; death as a result of an accident; suicide; or death of an unknown or other cause. Death of a participant from an expected cause is reportable as a non-critical incident.

Table 3 outlines reportable incidents that must be reported to the Division. Reportable incidents must be reported within three (3) business days after assuring the participant's health and safety or, in the event of death, within three (3) business days of being notified of the incident.

Table 3
Reportable Incident Definitions

Incident	Definition
Use of Restraint, including injuries caused by a restraint	The use of a physical, chemical, or mechanical means to prevent a participant from full freedom of bodily movement. Injuries caused by the use of restraint must also be reported.

Unauthorized Use of Restrictive Interventions	The use of a restrictive intervention outside of the participant's service plan and without following the appropriate required steps. Please see the Restrictive Intervention section for further information.
Seclusion	The involuntary confinement of a participant alone in a room or an area from which the participant is physically prevented from leaving or having contact with others
Serious Injury	Any harm, including disfigurement, impairment of any bodily organ, skin bruising, laceration, bleeding, burn, fracture or dislocation of any bone, subdural hematoma, malnutrition, dehydration, or pressure sores.
Elopement	The unexpected or unauthorized absence of a participant for more than is approved in the participant's service plan when that person is receiving waiver services, or the unexpected or unauthorized absence of any duration of a participant whose absence constitutes an immediate danger to themselves or others. This could be an unexpected participant action, which may not be intentional and may be due to wandering that is secondary to dementia.
Medical or Behavioral Admission and ER Visits	A participant's admission to a medical or behavioral institution or emergency room that is not a scheduled medical visit and occurs while the participant is receiving CCW services.
Death	Death that does not meet the definition of unexpected.

Provider Response

When an incident occurs, the provider is responsible, first and foremost, for addressing the immediate health and safety needs of participants, which may include contacting appropriate first responders. Providers are responsible for adequate and timely response commensurate with the circumstances of the incident. Response should be conducted per the service plan, and address the concerns raised in the incident.

The Division is responsible for evaluating the actions taken by the provider to ensure that adequate and timely response occurred. If the Division determines that a provider's actions are insufficient, the Division may require the provider to conduct immediate follow-up actions. Examples of these actions could include:

- Notifying the participant's family/guardian;
- Transferring the participant from the place of the incident;
- Making a referral for a medical examination or mental/behavioral health evaluation;
- Implementing the participant's backup plan to provide needed support;

- Assisting the participant to change providers;
- Coordinating with the case manager to modify the services or the scope, frequency, or duration of services in the service plan;
- Referring the participant to other support agencies such as the Wyoming Long-Term Care Ombudsman Program or Wyoming Protection and Advocacy; or
- Other necessary actions.

The provider must monitor the issues related to an incident until the incident has been closed by the Division. The provider must document the participant's current status, any outstanding issues related to the incident, incident resolution including actions taken by the provider and other involved parties, how the issues will be resolved, and how such incidents will be avoided in the future. New assessments, risk mitigation plans, service plan updates, or other actions may be required of the participant's case manager. An incident is not considered resolved until the Division makes the determination that all necessary follow-up activities have been conducted.

Division personnel will work directly with individuals involved in the incident if follow-up activities are needed. These follow-up activities may not be disclosed to other individuals not directly impacted by the incident or associated follow-up; however, Division personnel will ensure that appropriate follow-up and referrals to other agencies occur as required.

Reporting Process

The provider is responsible for reporting the incident to the Division in a timely and accurate manner using the WHP portal. The provider must gather necessary information in order or report a clear, detailed, and accurate account of the incident. This information can include the names of individuals working with the participant, events that occurred before, during, and after the incident, and the staff response to the incident.

A detailed, step-by-step description for reporting incidents can be found on the homepage of the HCBS Section website, under the *Reporting Critical Incidents and Complaints* section.

Once the provider submits the report, they will be redirected to a confirmation page that allows the provider to print the report. Even if a provider does not print the report, they should save a copy of the incident to give to the case manager and keep for their files.

Reporting Complaints

In addition to the incident reporting system, the Division also maintains an electronic complaint system. This complaint system is public-facing and linked to the homepage of the HCBS Section website in order to allow for any individual to lodge a complaint on behalf of a participant. This system is not intended for providers to report on situations with participants in their services; those concerns should be reported as incidents. However, if a provider has a complaint or concern regarding a participant when they are not in services, it may be appropriate to report

as a complaint. Other complainants may include the participant, case manager, family member or other natural support, or other community member.

During the initial enrollment and annual service plan meetings, case managers must provide participants with contact information for the case manager, the case manager's supervisor if applicable, and the Long-Term Care Ombudsman. The case manager must also explain the role of the Long-Term Care Ombudsman. More information on the Long-Term Care Ombudsman program can be found at https://health.wyo.gov/admin/long-term-care-ombudsman-program/.

Filing Process

A detailed, step-by-step description for reporting complaints can be found in the Provider Complaint Process Guidance Document, which is located on the HCBS Document Library page of the HCBS Section website, under the *Technical Guidance* tab.

Once the provider submits the complaint, they will be redirected to a confirmation page that allows the provider to print the complaint. Even if the provider does not print the complaint, they should save a copy of the complaint for their records.

Division personnel will contact the complainant and the party against which the complaint was filed in order to conduct additional follow-up and review as required. Division personnel are required to determine whether violations of CCW regulations have occurred within the complaint, and to refer the complaint to the appropriate investigative authorities as required. Division personnel will conduct follow-up as appropriate, but this follow-up may not include individuals who are not directly associated with the follow-up action.

Internal Complaints

If a provider receives a complaint or grievance from a participant or another individual, the provider must work with the participant and plan of care team members to resolve the complaint. Providers must maintain and follow an internal grievance policy within their organization to resolve complaints. Resolution may include, but is not limited to:

- Finding a new provider agency;
- Contacting the provider agency to request a change of caregiver;
- Assisting the participant in selecting a new case management agency;
- Assigning a new case manager;
- Revising the service plan based on the participant's needs; or
- Conducting an internal investigation and reporting findings to the Division.

The provider must document all complaints and grievances received, including resolution, as it relates to the services provided by the agency or those authorized to provide services for the participant.

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Division Follow-Up of Incidents and Complaints

The Division reviews all reported incidents and complaints within three (3) business days. The purpose of this review is to assure the health and safety of participants and to evaluate the provider's actions to determine if they were commensurate with the circumstances of the incident and were in compliance with state and federal rules and regulations. If Division personnel conclude that the provider has acted in accordance with rules and regulations, the Division closes the incident or complaint; if Division personnel conclude that the provider has not acted in accordance with rules and regulations, or has not completed required follow-up actions, the Division may offer technical assistance or issue corrective or adverse action to the provider.

Other Division Oversight and Support

The Division is required to provide certain assurances as part of the CCW Agreement. Among these assurances are that providers are qualified for the services they deliver, that service delivery meets state and federal standards, and that participant rights are respected. In order to meet these assurances, the Division provides oversight and support to providers through several mechanisms, including technical assistance, corrective action, and adverse action.

Technical Assistance

The role of the Division is to assist CCW providers in understanding and applying state and federal law and regulation related to the program, which helps to drive quality service delivery. Technical assistance is a broad term referring to the ongoing support the Division delivers to providers and other stakeholders. Technical assistance may be informal or formal, and is focused on compliance with regulations that support safe, quality service delivery. Informal or formal technical assistance can be issued by any Division staff member.

Providers may receive information from the Division regarding how to obtain or maintain program compliance, or information regarding a specific piece of regulation. These interactions qualify as informal technical assistance, and may include:

- Phone calls;
- Emails;
- Provider Support Calls or other large-scale informational calls;
- Documents and announcements on the HCBS Section website; and
- Information or guidance from Division personnel.

Technical assistance also includes connecting providers with information that the Division has previously offered. Division personnel may provide links or documents for review and reference. Providers should maintain this information for further reference. Additionally, providers should ensure that they are referring to the most current version of guidance documents such as program rules, service definitions, manuals, and other information. The Division sends notifications and updates website links when updated information and materials become available.

Formal technical assistance is typically issued in writing, and is often on official letterhead. Formal technical assistance can be provided in more serious situations to ensure that providers have an understanding of the Division's response or suggestion to a particular situation.

When Division personnel issue formal technical assistance, they have identified a concern with a provider's response to a rule violation or an identified area for improvement. This assistance is aimed at resolving issues that may arise and the lowest and most direct level possible. The technical assistance that is provided is intended to help the provider improve their systems or response in order to better handle similar situations in the future. The provider must follow the guidance and recommendations provided by the Division. If the provider fails to implement the necessary changes, they will be subject to a more formal follow up action.

Technical assistance is limited to applicable state and federal regulations that govern HCBS programs, as well as compliance with CCW program standards. Division personnel cannot provide technical assistance on business decisions, except when such decisions are in violation or potential violation of programmatic regulation. Additionally, the Division will not offer technical assistance on interpersonal conflict, except in situations when such conflict impacts service delivery.

Technical assistance offered to providers is noted in the provider profile maintained by the HCBS Section. Documentation regarding provider compliance allows the HCBS Section to demonstrate remediation of individual issues as outlined in the CCW Agreement.

Corrective Action

If technical assistance is offered on multiple occasions to the same provider related to the same or similar situations, the Division may be required to provide a higher level of support. Corrective action is a formal action that the Division imposes on the provider to correct an identified deficiency or violation. If a provider does not make changes after technical assistance is given, or if the issue is considered serious enough to warrant immediate action, the Division may issue corrective action. Please note that a corrective action plan alone is not an adverse action according to Chapter 16 of Wyoming Medicaid Rules, so a provider does not have the right to a fair hearing if the Division imposes corrective action.

When the Division imposes corrective action on a provider, the provider must develop and submit a plan within the specified time frame that explains the steps they will take to make the necessary corrections. This corrective action plan (CAP) must adequately address the area of non-compliance, and include detailed action steps the provider will take to ensure the correction is made now and in the future, the person responsible for ensuring the correction is made, the date by which the correction will be made, and the actual date of completion.

The purpose of the CAP is to ensure the provider complies with regulations and to assist the provider in making systemic improvements to their practices in order to address underlying issues that decrease the effectiveness or safety of the services they provide.

If a CAP is required, HCBS Section personnel will send information to the provider regarding the areas of noncompliance. Each area of noncompliance will be cited, and one or more action steps are required to address the area of noncompliance. Providers must submit CAPs using the WHP portal. More information on submitting CAPs can be found in the Electronic Corrective Action Plan (CAP) Guidance Manual, which is located in the HCBS Document Library, under the *Technical Guidance* tab.

The provider should remember the components of SMART goals when they develop a CAP:

- Action items should be **S**pecific - explain what will be accomplished.
- Action items should be **M**easurable - explain what will be measured, and what success will look like.
- Action items should be **A**chievable - ensure the action is doable.
- Action items should be **R**ealistic and **R**elative - ensure the action addresses the problem, and doesn't promise something that can't be delivered.
- Action items should be **T**imely - establish the time frame for accomplishing the action, and how often progress will be measured.

Providers are responsible for completing and submitting the CAP in the time frame outlined by HCBS Section staff. Once the CAP is reviewed by the HCBS Section, the provider will be notified if the CAP has been approved, rejected, or if there is a request for additional information. If the CAP is approved, the provider is responsible for implementing the CAP according to the time frames outlined in the CAP. If the CAP is rejected, the provider is responsible for resubmitting the CAP or for completing adverse action as designated by the HCBS Section.

The Division may review the provider's compliance with the CAP at any time to assure the provider has fully implemented and evaluated the CAP, and that participants remain safe during its implementation. The Division and the provider will work together to ensure that the CAP is completed and can be closed out in the appropriate time period.

Corrective action and the provider's obligation to develop, submit, and implement a CAP is intended to help the provider improve their systems and avoid ongoing issues that may result in an incident. Once the CAP is implemented and closed, the provider is obligated to ensure that the deficiency addressed in the CAP is not repeated. However, the provider should also be able to move on, continue to provide services, and know that the CAP experience improved their services and systems.

Adverse Action

Chapter 1 of Wyoming Medicaid Rules defines an adverse action imposed on a provider as the termination, suspension, or other sanction of a provider, the denial or withdrawal of admission certification, the determination of a per diem rate, or the denial or reduction of a Medicaid payment to a provider. An adverse action may be issued by the Division when there are serious concerns regarding violations of rule and regulation, or serious concerns that have not been addressed by the provider. An adverse action is a higher level of follow-up by the Division, but is still typically intended to allow the provider to come into compliance. Adverse actions are more

rare than technical assistance and corrective action, and can range in severity.

Chapter 16 of Wyoming Medicaid Rules provides some examples of adverse actions, including:

- Educational intervention;
- Recovery of overpayments;
- Suspension of payments;
- Suspension or termination of the provider agreement;
- Placing conditions on the provider;
- Imposing a monitor;
- Imposing civil monetary penalties; or
- Imposing an immediate suspension.

If a provider receives an adverse action, they must follow the instructions they receive from the Division. They must also communicate with Division personnel on a regular basis during the time that the adverse action is in effect.

Providers have the right to dispute an adverse action. Per Wyoming Medicaid Rule, providers must first request reconsideration, in writing, regarding the adverse action. To request reconsideration, the provider must send the request by certified mail, return receipt requested, or personally deliver the request to the Division offices on the 4th floor, West Wing of 122 W. 25th Street in Cheyenne, within twenty (20) business days after the mailing of the notice of adverse action. Other rules related to adverse actions are found in Chapter 4 of Wyoming Medicaid Rules.

Not all actions are considered to be adverse actions that are subject to the hearing process. According to Chapter 1 of Wyoming Medicaid Rules, the following terminations, suspensions, or other sanctions are ***not*** considered adverse actions.

- A termination, suspension, or other sanction based on the provider's loss of or failure to provide documentation of required licensure or certifications.
- A termination, suspension, or other sanction based on a provider's exclusion by the Office of the Inspector General (OIG) or termination by Medicare; and
- A termination, suspension, or other sanction based on a finding of fraud, abuse, or other prohibited activities by a judicial or administrative process where the provider was afforded notice and the right to a hearing.

Additionally, the following reductions, denials, or recoveries of overpayments are not adverse actions:

- A reduction, denial, or recovery described in Section 12(c)(d) and (e) of Chapter 16 of Wyoming Medicaid Rules;
- A reduction, denial, or recovery due solely by a change in federal or state law; or
- An appeal of a rate setting methodology.

Section 7. Fraud, Waste, and Abuse

Medicaid fraud is an intentional deception or misrepresentation made for profit or other benefit. Simply put, fraud is intentionally providing false information to get Medicaid to pay for medical care or services. Medicaid fraud can involve physicians, pharmacists, other Medicaid providers, and even beneficiaries. Types of provider fraud are outlined in Table 4.

Table 4
Types of Medicaid Fraud

Activity	Explanation
Card Sharing	Knowingly treating and claiming reimbursement for someone other than the eligible beneficiary.
Collusion	Knowingly collaborating with beneficiaries to file false claims for reimbursement. Submitting time sheets for services that were not rendered (participant-directed).
Kickbacks	Offering, soliciting, or paying for beneficiary referrals for services or items.
Program Eligibility	Knowingly billing for an ineligible beneficiary.
Billing Discrepancies	Intentionally billing for unnecessary services or items or for services or items that were not provided.

Beneficiary fraud may include, but is not limited to, the activities outlined in Table 5:

Table 5
Types of Beneficiary Fraud

Activity	Explanation
Card Sharing	Sharing a Medicaid identification card with someone else so they can obtain services.
Collusion	Helping a provider file false claims by having unnecessary tests conducted. Approving timesheets for services that were not rendered (participant-directed).
Kickbacks	Accepting payment from a provider for referring other beneficiaries for services.
Program Eligibility	Providing incorrect information to qualify for Medicaid.

Waste encompasses the overutilization of resources and inaccurate payment for services, such as providing services that the participant does not need. Abuse includes any practice that is inconsistent with acceptable fiscal, business, or medical practices that unnecessarily increases costs.

Prevention and Education

Federal and state initiatives are underway to combat Medicaid fraud, waste, and abuse. Initiatives include data mining, audits, investigations, enforcement actions, technical assistance, and provider and member outreach and education. These initiatives ensure that:

- Eligibility decisions are made correctly;
- Prospective and enrolled providers meet federal and state participation requirements;
- Delivered services are necessary and appropriate; and
- Provider payments are made in the correct amount and for appropriate services.

Providers can only submit claims for services that have been delivered to participants who are eligible for the waiver and are residing in the community. Providers cannot submit claims for services when a participant is:

- In a nursing facility;
- In a hospital;
- Deceased; or,
- Otherwise unable to receive services.

In accordance with 42 CFR 447.45(f), the Division must ensure that a prepayment review of all claims is conducted to ensure that the participant was eligible for the program at the time the services were provided, the services were authorized, the claim does not duplicate or conflict with other services, the requested payment does not exceed reimbursement rates or other limits in the Medicaid State Plan, and there is not a third party responsible for making the payment. The Division must also conduct a post-payment review of claims to ensure payments align with state and federal requirements.

Reporting Fraud, Waste, and Abuse

The Division's Program Integrity Unit is responsible for ensuring the integrity and accountability of all Wyoming Medicaid payments. CCW service providers must report suspected Medicaid fraud, waste, or abuse to the Division. For more information or to file a report online, visit https://health.wyo.gov/healthcarefin/program-integrity/.

Prohibition Against the Reassignment of Provider Claims

Claims for reimbursement must represent the services rendered by the enrolled provider or staff member under the direct employment, supervision, and control of the enrolled provider. Providers may not reassign claims, act as a pass-through entity, or act as an intermediary for services rendered by another party under the CCW program.

Prohibitions Against the Collection of Payment from Participants

Providers may not impose the cost of co-pays or cost sharing on participants. Providers accept Medicaid reimbursement as payment in full for covered services and may not collect or attempt to collect any additional payments from the participant or the participant's family. Providers

may not charge participants for services that would have been covered under CCW services, whether or not the provider has actually submitted a claim for Medicaid reimbursement.

Providers may collect or attempt to collect payment from participants or the participant's family when the goods or services rendered extend beyond the amount, scope, or duration covered by the Wyoming Medicaid State Plan or the CCW program. However, the provider must inform the participant of the potential charges, in writing, before they begin services, annually, and any time the charges change. The provider is solely responsible for the collection of such payment.

Anti-Kickback Standards

In addition to the conflict of interest safeguards for HCBS waivers, federal law prohibits the use of kickbacks. A kickback is offering, paying, soliciting, or receiving anything of value to induce or reward any person for purchasing, ordering, or recommending or arranging for the purchasing or ordering of federally-funded medical goods or services. Criminal penalties for violation of the Anti-Kickback Statute include fines up to $25,000 per violation and up to five years in prison per violation. Violations can also result in civil penalties including the exclusion from participation in federal healthcare programs, civil monetary penalties of up to $50,000 per violation, and civil assessments up to three times the amount of the kickback.

The Health Insurance Portability and Accountability Act (HIPAA) Beneficiary Inducement Prohibition forbids providers from providing or offering any remuneration, including free or discounted items, to any Medicare or Medicaid beneficiary that is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services. Violations of the HIPAA Beneficiary Inducement Prohibition may result in civil monetary penalties of up to $10,000 per wrongful act.

CCW providers are prohibited from using kickbacks or inducements to incentivize or reward individuals for using their services, and from receiving items or compensation for influencing a participant's choice of the providers included in the service plan.